PRINTED: 07/18/2011

	T OF HEALTH AND HU						ORM APPROVED
	R MEDICARE & MEDI					OMB NO. 0938-0391	
1	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/23/2011	
HICKOR	PROVIDER OR SUPPLIE	ENSBURG	'	1620 N GREEN	ADDRESS, CITY, STATE, ZIP CODE LINCOLN ST NSBURG, IN47240	•	1 970
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0000	State Licensure included the Inv IN00090957. Complaint IN0 No deficiencies are cited.	er: 155353 100288790	F0	000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements establis by state and federal law. Hickory Creek at Greensburgers this Plan of Correct to be considered the facility Allegation of Compliance. Compliance is effective on 23, 2011.	is n / d shed urg tion y's	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Penny Marlatt, RN Diana Sidell, RN (6/22,6/23,2011)

Census bed type: SNF/NF

Census Payor type: Medicare Medicaid

Total

Other

Total

29 29

24

4

29

Event ID:

SGR511

Facility ID:

000244

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155353	B. WIN			06/23/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					LINCOLN ST		
HICKOR	Y CREEK AT GREE	NSBURG		GREEN	ISBURG, IN47240		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	Sample: 10						
	Tl 1. C						
		es reflect state findings					
	cited in accordance with 410 IAC 16.2.						
	Quality review com	pleted on June 28, 2011 by					
	Bev Faulkner, RN						
F0250	The facility must p	rovide medically-related					
SS=D		attain or maintain the					
		e physical, mental, and					
	psychosocial well-being of each resident. Based on record review and interview, the			250	F 250 Social Services It is the		07/23/2011
	facility failed to ensure follow-up with the		10	230	policy of this facility to prov		07/23/2011
	1	*			medically-related social		
	1	n on the psychologist's			services to attain or mainta	<u>in</u>	
		to increase a resident's			the highest practicable		
	_	edication. This affected 1			physical, mental, and		
		viewed for psychoactive			psychosocial well-being of	.	
	medications in a	sample of 10. (Resident			each resident. 1. What		
	#10)				corrective action(s) will be accomplished for those		
					residents found to have been	en	
	Findings include	<u>.</u>			affected by the deficient		
					practice? On June 23, 2011	_	
	The record review	w of Resident #10 on			resident #10's attending		
	6/23/2011 at 8:30	a.m., indicated the			physician was notified and		
	resident was adm	nitted with, but not			updated on the Psychologis recommendation of June 15		
		lowing diagnoses:			2011 to increase Lexapro to		
		s, depression, anxiety,			mg every day. On June 23,		
	coronary artery d				resident # 10's attending		
	cerebrovascular a	-			physician gave new orders		
		e resident had a current			increase Lexapro to 20mg b	<u>oy</u>	
	_	o 10 mg daily at bedtime.			mouth every day for depression. Resident #10's		
	oraci ioi Ecaupio	c 10 mg ann, at boatime.			family was notified of the ne	- 1	
	Review of Psych	ologist's "FAX			order and resident # 10's ca		
	l -	SHEET," dated 2/15/11,			plan was reviewed and upd		
		ommendation to increase			as needed. 2.How other		
	mulcated his feet	Jimmenuation to mercase			residents having the poten	<u>tial</u>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPLETED
		155353	B. WIN			06/23/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				LINCOLN ST	
HICKUD.	Y CREEK AT GREE	NSBLIDG			ISBURG, IN47240	
піскок	T CREEK AT GREE	NSBURG		GREEN		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Resident #10's L	exapro to 20 mg every			to be affected by the same	
	day. "CURREN"	T STATUS OF			practice will be identified a	
	CONDITION:" indicated Resident #10				what corrective action(s) w	<u>ill</u>
	with increasing depression, social				be taken? Every resident	
	isolation, and increased agitation.				residing in the facility shall	-
	· ·	C			have their medical record	
	This fax transmittal sheet had				audited to ensure all	
	"Agree (X) Disagree (X)				recommendations, including	<u>ıg</u>
					psychologist recommendations have bee	n
	Date Attending Physician"				addressed by the attending	
		3			physician. If any resident(s	
	The Transaction Report indicated the fax				identified as having	<u> </u>
		to Resident #10's primary			outstanding recommendati	on
					including psychologist	<u> </u>
	physician on 2/10	6/2011 at 12:26 P.M.			recommendations that have	e
					not been communicated an	
	A social services	progress note, dated			addressed by the attending	
	2/16/11, included	d "Resident was seen by			physician, the Director of	_
	· ·	ist's name] on 2/15/11 his			Nursing or designee will no	otify_
		s were to increase			the attending physician	
		g, waiting for [name of			immediately and document	<u>: in</u>
					the resident's medical reco	<u>rd.</u>
	attending MD] re	esponse."			3.What measures will be pu	
					into place or what systemic	<u> </u>
	During an intervi	iew with the SSD[Social			changes will be made to	
	Services Director	r] on 6/23/2011 at 11:40			ensure that the deficient	
	a.m., the SSD sta	ited, "I make a copy of			practice does not recur?	
	· ·	ame]'s recommendations			Recommendations from	
		Medical Doctor, then I			consultants, including	4.
		=-			psychologist, will be given	
		se to have her watch for a			nursing and nursing will no the resident's attending	oury
		D and I follow-up if the				
	MD doesn't reply	7."			physician of recommendations. These	
					recommendations will be fa	have
	Interview with e	mployee #5/LPN on			to the attending physician	
	Interview with employee #5/LPN on 6/23/2011 at 1:15 p.m., regarding the				nursing. Return fax is expe	
					within 24 hours; after 24 ho	
		w-up with primary			if no fax/phone is received,	
	physician on the	psychologist's			no tampitone is received,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	PLE CONSTRUC	CTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	_G 00		COMPLETED
		155353	B. WING			06/23/2011
			_	DEET A DIDDEC	S, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L.	•			
LUCKOD	V ODEEK AT ODEE	NODUDO		20 N LINCO		
HICKOR	Y CREEK AT GREE	INSBURG	6	REENSBUR	(G, IN47240	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREF	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TA		SS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	recommendation	s. She replied, "Social		faci	ility will contact the	
	Services Director			atte	ending physician by pho	ne.
		s and nursing writes		<u>As</u>	a reminder to nursing fo	<u>r</u>
		C		foll	ow up, the original requ	<u>est</u>
	_	and sends to pharmacy		<u>will</u>	be maintained with the	24
	•	es with medication			ur report sheet until the	
	recommendation	s." "Sometimes the		I -	uest is answered by the	
	doctor takes a lo	ng time to reply." "We			sician. The Director of	
		it let the doctor reply to			rsing will inservice licen	
	,	mendations were made		I -	ses on this policy on Ju	
		th the original fax		I -	2011. At least 5 days pe	
		_		I -	ek, the DON or designee	
	•	loyee #5/LPN stated, "I			iew the 24 hour report a	<u>1a</u>
	_	l the office." Employee		I -	us charting for any	
	#5/LPN received	a fax from the resident's			standing recommendation	
	primary care phy	vsician, dated 6/23/2011 at			t have not been address	
		ng to increase Resident			the physician. The DON signee will document	<u>or</u>
		er the Psychologist		I -	dings on QA Audit form	
		_			50, 5 days per week. If	the
		s on 2/15/2011. The			N identifies a transmittal	
		ian signed and dated			24 hour report that the	<u> </u>
	agreement as, "2	/16/11."			ending physician has no	t l
					ressed within 24 hours,	
	3.1-34(a)				immediately ensure the	
	. ,				ending physician is notif	
				One	ce the attending physicia	an_
				<u>has</u>	been notified, the DON	<u>will</u>
				<u>retr</u>	rain the staff member(s)	
				inve	olved. In addition,	
				pro	gressive disciplinary ac	tion_
					be taken for continued	
					ncompliance. This proc	
					continue indefinitely an	
					an ongoing basis. 4. Hov	<u>v</u>
					corrective action be	
					nitored to ensure the	
					icient practice does not	
					ur and what QA will be p	
				into	place? While the proce	<u>55</u>
				-		

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00	(X3) DATE COMP! 06/23/2	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION DATE	
F0371 SS=F	considered satisfal local authorities; a (2) Store, prepare, under sanitary corn Based on observative record review, the routine chlorine to conducted on the using the numeritest strip package has the potential	distribute and serve food diditions ation, interview, and e facility failed to ensure testing was properly dietary area dishwasher, c values provided on the e. This deficient practice to adversely affect 29 of receive food or drink	F0371	of the DON reviewing hour reports, focus of and faxes to the physicast 5 days per week ongoing, the docume the reviews will be dethrough the next 30 of that time frame is conthe QA &A committed determine the continuous frequency of the review documentation. The bring the results of the audit to the interdisce team meeting 5 days the weekly Standard meeting, the monthly meeting and to the quantum QA&A meeting that is by the medical direct review and recomme Date of compliance July 2011. F 371 Sanitary Conditions of Compliance July 2011.	charting sician at k is entation of one days. Once mpleted, e will ued ew DON will he QA iplinary s per week, of Care / QA&A uarterly s attended for for ndations. July 23, ons ons ons ersidents cted by the erformed the ish machine of oassure aware and	07/23/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SGR511

Facility ID:

000244

If continuation sheet

Page 5 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ((X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155353	B. WIN			06/23/2011
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				LINCOLN ST	
HICKOR'	Y CREEK AT GREE	NSBURG		1	ISBURG, IN47240	
						1 775
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
IAU	REGULATORT OR	ESC IDENTIFTING INFORMATION)	•	IAU	noted to be functioning at the pr	
					levels.	lopei
	Findings include	:			ieveis.	
					Per facility policy and manufac	tures
	During an observation of the operation of				recommendations the chlorine	
	the dishmachine	on 6-22-11 at 9:40 a.m.,			residual level of low temperatur	re
	Dietary Staff #1	demonstrated the			dish machines must be greater t	han
	conducting of the chlorine test. Upon				or equal to 50 ppm and less that	
		e test, she indicated the			equal to 100ppm. During survey	
	_				when staff performed the test for	
	results were "75" as the color was				surveyor the facility staff memb	
	between the package indicators of 50 and 100 ppm (parts per million).				indicated the ppm at "75" as it between 50 ppm-100 ppm.	was
					between 30 ppin-100 ppin.	
					2. How other residents having t	he
	The package was	s labeled as "pHyrion			potential to be affected by the s	
	Mico chlorine" a	nd indicated the possible			practice will be identified and w	
	choices for select	tion, based on the color			corrective action(s) will be take	<u>n?</u>
	result of the test	as 10, 50, 100, and 200.			The facility wishes to point out	
					there has been no actual residen	
	Dietary staff #1 r	recorded the result as			harm as a result of this practice.	
	1 *	ed, "Test for Low			During the months of April, M	
	Temperature Disl				and June, 2 2011 no residents widentified as reporting or	reie
	instructions for the				experiencing signs or symptoms	s of
					foodborne illnesses as a result	
	· ·	tmus test paper to check			biological contamination, chem	
		ily during each meal.			contamination or physical	
		be greater than 50 ppm			contamination.	
		ppm. Document				.
	findings of ppm	on the top of box"			The facility wishes to further po	
					out that the situations occurred	oniy
	Review of the me	onthly logs for chlorine			occasionally.	
		for the month of May			The dish machine chlorine is	
	~	led between 110 and 120			checked by Gordon's F ood Ser	vice
	for the breakfast meal; between 120 and 130 for the lunch meal and between 100 and 120 for the dinner meal. For the				representative on a monthly bas	
					was checked and serviced on A	pril 7,
					2001, May 3, 2011 and June 22	,
					2011.	
	month of June 20	011, values varied				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155353 06/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1620 N LINCOLN ST HICKORY CREEK AT GREENSBURG GREENSBURG, IN47240 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE between 75 and 120 for the breakfast During the survey all dietary staff meal; between 20 and 120 for the lunch were inserviced by the Dietary meal and between 80 and 120 for the Manager. All dietary staff shall be dinner meal re-inserviced by the Registered Dietitian on July 8, 2011. The inservice shall include chlorine In interview with the Dietary Manager on monitoring and return demonstration 6-22-11 at 2:50 p.m., she indicated she by all dietary personnel, and had began earlier this date to inservice all corrective action to be taken in the of the dietary staff in regard to properly event the chlorine monitoring is less conducting the chlorine test on the than 50 ppm or greater than 100 ppm. dishmachine. She provided a copy of her inservice from earlier that date. The 3. What measures will be put into inservice information indicated, "Chlorine place or what systemic changes will should be greater than 50 ppm and less be made to ensure that the deficient than 100 ppm...you should never put a practice does not recur? As stated above, all dietary staff were number like 88 or 97. It should be 50, 75 inserviced by the Dietary Manager or 100. You have to have it read like the during the survey. All dietary staff chlorine strips..." shall be re-inserviced by the Registered Dietician on July 8, 2011. 3.1-21(i)(2)The inservice shall include chlorine monitoring and return demonstration by all dietary personnel and corrective action to be taken in the event the chlorine monitoring is less than 50 ppm or greater than 100 nnm 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Dietary Manager or designee will review chlorine monitoring logs for the dish machine at least 5 days per week. Copies of the completed logs shall be submitted to the facility

OF CORRECTION	IDENTIFICATION NUMBER: 155353	A. BUILDING B. WING	00	COMPLETED 06/23/2011
PROVIDER OR SUPPLIER Y CREEK AT GREE		STREET / 1620 N	ADDRESS, CITY, STATE, ZIP CODE LINCOLN ST NSBURG, IN47240	1
Y CREEK AT GREE SUMMARY S (EACH DEFICIEN		STREET / 1620 N	LINCOLN ST	weekly eview at each on the istrator ary ag the orine e oleted, uency ring ing ing ing e
			quarterly QA&A meeting tha attended by the medical director review and recommendations. Date of compliance: July 23, 2	ons.

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155353	B. WING	<u> </u>	06/23/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		ı	I LINCOLN ST	
HICKOR'	Y CREEK AT GREE	NSBURG	l l	NSBURG, IN47240	
				11020110, 1111/210	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	BEFEIENCT)	DATE
F0385 SS=D	a recommendation admitted to a facility remain under the of the facility must expressed on residents with physician is unavariable. Based on record facility failed to optimary care phystimely manner to recommendation antidepressant most of 7 residents reversed in the record review (6/23/2011 at 8:30 resident was admitted to the following the facility failed to a facility failed to the following the facility failed to a facility failed to a facility failed to the following the facility failed to the following the facility failed to a faci	review and interview, the ensure the resident's sician responded in a the psychologist's to increase the resident's edication. This affected 1 riewed for psychoactive sample of 10. (Resident w of Resident #10 on 0 a.m., indicated the nitted with, but not lowing diagnoses: s, depression, anxiety,	F0385	F 385 Residents Care Supervised by a Physicia It is the policy of this facthat a physician personal approve in writing a recommendation that an individual be admitted to facility. Each resident moremain under the care of physician. The facility must ensure the medical care of each resident is supervised by physician, and another physician supervises the medical care of the reside when their attending	ility lly D a ust T a that

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR COMPLETI	
AND PLAN	OF CORRECTION	155353	A. BUI	LDING	00	06/23/201 ²	
		100000	B. WIN			00/23/201	'
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
HICKUD.	Y CREEK AT GREE	NSBLIDG		1	LINCOLN ST SBURG, IN47240		
				<u> </u>			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	re C	COMPLETION DATE
1710	cerebrovascular a		+	1710	physician is unavailable.		DATE
					physician is unavanable.		
	hemiparesis. The resident had a current order for Lexapro 10 mg daily at bedtime.				1.What corrective action(s) wi	ll be	
	order for Lexapro	o to mg dany at bedume.			accomplished for those resider	<u>its</u>	
	A social services progress note, dated				found to have been affected by	<u>the</u>	
					deficient practice?	.	
	2/16/11,"Residen	-			On June 23, 2011 resident #10 attending physician was notific		
	1	ame] on 2/15/11 his			and updated on the Psycholog		
		s were to increase			recommendation of June 15, 2		
	1 '	g, waiting for [name of			to increase Lexapro to 20 mg e		
	attending MD] re	esponse."			day. Resident # 10's attending	.	
	During an interview with the SSD[Social				physician gave new orders to increase Lexapro to 20mg by		
					mouth every day for depressio	n.	
		r] on 6/23/2011 at 11:40			Resident #10's family was noti		
	1	ited, "I make a copy of			of the new order and resident	<u># 10'</u>	
	1	ame] recommendations			s care plan was reviewed and		
		D[Medical Doctor], then			updated as needed.		
		rse to have her watch for			2.How other residents having t	the	
		and I follow-up if MD			potential to be affected by the		
	doesn't reply."				same practice will be identified		
					and what corrective action(s)	<u>will</u>	
	Review of Psych	_			be taken?		
	TRANSMITTAL	SHEET," dated 2/15/11,			Every resident residing in the facility shall have their medica		
	indicated his reco	ommendation to increase			record audited to ensure all	<u></u>	
	Resident #10's L	exapro to 20 mg every			recommendations, including		
	day. "CURREN"	T STATUS OF			psychologist recommendations	<u>s</u>	
	CONDITION:" i	ndicated Resident #10			have been addressed by the		
	with increasing d	lepression, social			attending physician.		
	isolation, and inc	reased agitation.			If any resident(s) are identified	l as_	
	This fax transmit	tal sheet had			having outstanding	_	
	"Agree (X) Disagree (X)				recommendations, including		
					psychologist recommendation		
					have not been communicated a addressed by the attending	anu_	
	Date Atte	nding Physician."			physician, the Director of Nurs	sing	
					or designee will notify the		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED				
		155353	A. BUII B. WIN			06/23/20	
	PROVIDER OR SUPPLIER		P. WIN	1620 N I	DDRESS, CITY, STATE, ZIP CODE LINCOLN ST SBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	The Transaction Report indicated the fax was transmitted to Resident #10's primary physician on 2/16/2011 at 12:26 P.M.				attending physician immediate and document in the resident's medical record.	<u>s</u>	
	6/23/2011 at 1:15 process for follow physician on the recommendation Services Director recommendation telephone order a once doctor agreerecommendation doctor takes a lost try not to call, but the fax." Recommon 2/15/2011 wit 2/16/2011. Emp guess I better cal #5/LPN received primary care phy 1:31 p.m., agreei #10's Lexapro per recommendation	s. She replied, "Social of faxes psych is and nursing writes a sind sends to pharmacy ites with medication is." "Sometimes the ingitime to reply." "We it let the doctor reply to mendations were made in the original fax aloyee #5/LPN stated, "I let the office." Employee in a fax from resident's itesician, dated 6/23/2011 at ingiting to increase Resident in the Psychologist is on 2/15/2011. The item signed and dated the			3. What measures will be into place or what system changes will be made to ensure that the deficient practice does not recur? Recommendations from consultants, including psychologist, will be given to nursing and nursing will notifice resident's attending physician recommendations. These recommendations will be faxed the attending physician by nursing. Return fax is expected within 24 hours, after 24 hours no fax/phone is received, the facility will contact the attending physician by phone. As a remit to nursing for follow up, the original request is to be maintained with the 24 hours report sheet until request is answered by physician. The Diwill inservice licensed nurses of At least 5 days per week, the Diwill review the 24 hour report, focus charting for any outstan recommendations that have no been addressed by the physician The DON or designee will document finding on QA form F250 5 days per week. If the I identifies transmittal on the 24 hour report that the attending physician has not addressed w	v of d to d s, if ing nder ON on. OON ding ot an.	
					24 hours, she will immediately	<u>-</u>	

	T OF DEFICIENCIES OF CORRECTION	(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	A. BUILDING B. WING	00	COMPLETED 06/23/2011
	ROVIDER OR SUPPLIER		STREE 1620	T ADDRESS, CITY, STATE, ZIP CODE N LINCOLN ST ENSBURG, IN47240	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORY OR	LOC IDENTIFY ING INFORMATION)	IAG	ensure the attending physician notified. Once the attending physician has been notified, and progressive disciplinary action be taken for continued noncompliance. This process will continue indefinitely and on an ongoin basis. 4. How will corrective action monitored to ensure the definite practice does not recur and and QA will be put into place? While the process of the DOI reviews at least 5 days per wongoing, the documentation reviews will be done through next 30 days. Once that time is completed, the QA &A committee will determine the continued frequency of the redocumentation. The DON will bring the resurthe QA audit to the interdisciplinary team meeting days per week, the weekly Standard of Care meeting, the monthly QA&A meeting and quarterly QA&A meeting the attended by the medical director review and recommendated. Date of compliance July 23, 20 meeting and quarterly QA&A meeting the attended by the medical director review and recommendated.	be cient what Neek is of the the frame Eview Lts of mg 5 ne L to the at is ctor cions.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155353			ĺ	LDING	ONSTRUCTION 00	(X3) DATE COMPI 06/23/2	LETED
NAME OF I	PROVIDER OR SUPPLIER	t		1	ADDRESS, CITY, STATE, ZIP CODE LINCOLN ST		
HICKOR'	Y CREEK AT GREE	NSBURG		1	ISBURG, IN47240		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0387 SS=D	least once every 3 after admission, a days thereafter.	t be seen by a physician at 30 days for the first 90 days nd at least once every 60 s considered timely if it					
	occurs not later than 10 days after the date the visit was required.						
	Based on record	review and interview, the	FO	387	F 387 Frequency of Physicia	<u>ın</u>	07/23/2011
	facility failed to	ensure timeliness of an			<u>Visits</u>		
	initial physician	visit for 1 resident in a			It is the policy of this facility	v that	
	sample of 10 wh	o were reviewed for			residents must be seen by a		
	physician visits.	(Resident #17)			physician at least once ever		
	Finding include:				days for the first 90 days aft admission, and at least once	every	
					60 days thereafter. (2) A ph		
	Resident #17's cl	linical record was			visit is considered timely if i occurs not later than 10 day		
		1-11 at 3:47 p.m. His			the date the visit was requir		
		ed, but were not limited			-		
		labetes mellitus type 2,			1. What corrective action(s)		
	•	ght loss related to			accomplished for those reside found to have been affected		
		le dementia, hypertension,			deficient practice?	by the	
		disease, benign prostatic			Resident #17 was seen by th		
	hypertrophy (enl	arged prostate), and			attending physician on Apri		
	depression. Resi	ident #17 was admitted to			and on April 26, 2011 at Dec County Memorial Hospital.		
	the facility on 4-	26-11.			Resident # 17 was seen agai	_	
					the attending physician Apr		
	Review of the ph	nysician visits indicated			and on June 15, 2011 this fa	cility.	
	his physician ma	de an initial visit on			The facility wishes to point	out	
	6-15-11. This w	as 50 days after the			that resident #17 was seen b		
	resident was adm	nitted into the facility.			attending physician at least		
					every 30 days as he was seen		
	On 6-22-11 at 11	:30 a.m., the Director of			the attending physician on A 24th, April 26th and again o		
	Nursing provided	d a copy of a policy			24th, April 26th and again 6 15, 2011.	on June_	
	entitled, "Physical	ian Visits," with an issue			-		

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/23/2011
	PROVIDER OR SUPPLIER		STREET A 1620 N	LINCOLN ST ISBURG, IN47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Director of Nurs current policy. T admissions and N	4. In interview, the ing indicated this was the he policy indicated, "New Medicare residents will be visician every 30 days for "		Per federal guidelines F-tag 3 interpretive guidelines 483.40 "Must be seen" means that the physician must make an actustace-to-face contact with the resident. There is no requirent for this type of contact at the of admission, since the decision admit an individual to a nursifacility (whether from a hospifrom the individual's own residence) generally involves physician contact during the period immediately preceding admission." 2. How other residents having potential to be affected by the same practice will be identified and what corrective action(s) be taken? No other residents were affect by this deficient practice. On July 7, 2011 an audit was completed on all new admission within the last 60 days to ensure that the least once every 30 days for the first 90 days after admission, at least once every 60 days thereafter per federal guideling and per facility policy. 3. What measures will be put in place or what systemic change will be made to ensure that the deficient practice does not reconstructed the DON and MDS coordinator/medical records designee on the facility	(c): te time to to tal or the the

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155353	B. WIN			06/23/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹					
LUCKOD	V ODEEK AT ODER	NODUDO			LINCOLN ST		
HICKORY CREEK AT GREENSBURG				GREEN	ISBURG, IN47240		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
					policy/procedure for physicia	<u>n_</u>	
					visits on July 15, 2011.		
					Per facility policy, the		
					MDS/medical records designed	e will_	
					track physician visits to ensur	<u>·e</u>	
					residents are being seen on a		
					timely basis. The MDS/medic	_	
					records designee will notify th		
					physicians of visits due at the		
					beginning of each month and	<u>will</u>	
					keep documentation of the		
					notifications. If the physician		
					continually untimely with visi		
					the Administrator will notify		
					Medical Director for assistant	<u>ce</u>	
					and guidance.		
					The Administrator and/or Me		
					<u>Director will send a letter to t</u>		
					physician requesting a visit be		
					made for regulatory complian	ice.	
					4.How will corrective action b		
					monitored to ensure the defic		
					practice does not recur and w		
					QA will be put into place?		
					The process of the MDS/medi	cal	
					record designee tracking physical		
					visit and notifying physicians		
					visits due at the beginning of		
					month is ongoing. As stated a		
					if the physician is continually		
					untimely with visits, the		
					Administrator will notify the		
					Medical Director for		
					assistance/guidance. The		
					Administrator and/or Medica	<u>1</u>	
					Director will send a letter to t	<u>he</u>	
					physician requesting a visit be		
					made for regulatory complian	ice.	
					This process will also be ongo	ing.	
					<u>-</u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	l		00	COMPL	ETED
		155353	A. BUIL			06/23/2	011
		100000	B. WING			00/20/2	011
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1620 N	LINCOLN ST		
HICKOR'	Y CREEK AT GREE				ISBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
					While the above is an ongoing	_	
					process, at least five days per		
					week, the MDS/medical record		
					designee will review the 24 hor		
					report to identify new admissi	<u>ons</u>	
					for the purpose of tracking		
					physicians visits. Documentati		
					the reviews will be done for th		
					next 30 days using QA audit to	ool F	
					387. Once this time frame is	4	
					completed the QA&A commit	<u>tee</u>	
					will determine the continued frequency of the review		
					documentation.		
					documentation.		
					The MDS/medical records		
					designee will bring the results	of	
					the QA audit to the	01	
					interdisciplinary team meeting	g 5	
					days per week, the weekly		
					Standard of Care meeting, the		
					monthly QA&A meeting and t		
					quarterly QA&A meeting that		
					attended by the medical direct		
					for review and recommendation		
					Date of compliance :July 23, 2		
					<u>-</u>		
					<u>-</u>		
					<u>-</u>		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ND IC	00	COMPL	ETED
		155353	A. BUILI B. WING			06/23/2	011
			B. WING	_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	1			LINCOLN ST		
HICKOR'	Y CREEK AT GREE	NSBURG	GREENSBURG, IN47240				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ļ	TAG	DEFICIENCY)		DATE
F0441 SS=D	Infection Control F a safe, sanitary ar and to help prever	establish and maintain an Program designed to provide and comfortable environment on the development and					
	transmission of disease and infection.						
	Program under wh (1) Investigates, coinfections in the fa (2) Decides what pisolation, should be resident; and (3) Maintains a red	establish an Infection Control nich it - ontrols, and prevents icility; procedures, such as le applied to an individual cord of incidents and related to infections.					
	(1) When the Infect determines that a prevent the spread must isolate the re (2) The facility mu communicable dis lesions from direct their food, if direct disease. (3) The facility mu hands after each of the determines that the spread of t	ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin t contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted					
	transport linens so infection. Based on record facility failed to TB[tuberculosis] within 48 to 72 h	andle, store, process and o as to prevent the spread of review and interview, the ensure a resident's Mantoux test was read fours after administered.	F04	.41	F 441 Infection Control It is the policy of this facility to maintain an infection control program designed to provide a safe, sanitary and comfortable	<u> </u>	07/23/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155353	A. BUI	LDING	00	06/23/2011
		199393	B. WIN			00/23/2011
NAME OF	PROVIDER OR SUPPLIEF	3			DDRESS, CITY, STATE, ZIP CODE	
HICKOR	Y CREEK AT GREE	ENSBURG		1	SBURG, IN47240	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	for TB Mantoux testing in a sample of 10.				environment and to help preve the development and transmis	
	(Resident #15)				of disease and infection.	<u> </u>
					of disease and infection.	
	Findings include	»:			1. What corrective action(s) w	ill be
					accomplished for those resider	
	On 6/22/2011 at	2:00 p.m., the record			found to have been affected by	<u>/ the</u>
	review of Reside	ent #15, indicated that she			deficient practice?	.
	was admitted wi	th diagnoses that			Resident #15 was administered first step mantoux on 6/26/11 a	
	included, but we	ere not limited to anxiety,			results were read on 6/29/11. T	
	1	nia, fibromyalgia, colitis,			results were "0' mm induratio	
osteoporosis, allergies, and hypertension.					Resident # 15 did not receive a	
		S 2, a s JF 2 2 2 2			second step PPD, as the reside	<u>nt</u>
	Review of "RECORD OF T.B. TESTS				was discharged to home on	
	1	ZATIONS" for Resident			<u>7/3/2011.</u>	
	1	ne received a Mantoux			2. How other residents having	the
	1	t forearm] on 6/8/11			potential to be affected by the	
	1	-			same practice will be identified	<u>d</u>
	1	an LPN. The "Date Read"			and what corrective action(s)	<u>will</u>
	1	lumns contained no			be taken?	
	documentation.				Every residents medical recor	d
					shall be audited to ensure all 1	
	1	iew on 6/22/2011 at 2:30			step mantoux/PPDs and 2nd s	
	1 * *	oyee #5/LPN, she stated,			mantoux/PPDs have been	
	•	ad, not documented any			administered and read per fac	<u>ility</u>
	1 ^	vill administer a new TB			policy or if PPD is	
		Friday, so I will be here			contra-indicated the audit will ensure that a CXR has been	-
	1	on Monday." Employee			completed and the resident is	free_
	#5/LPN indicate	d their policy and			of active TB.	
	procedure is the	same as the State			-	
	guidelines: 1st st	tep prior to or day of			3. What measures will be put i	l l
	admission, 2nd s	step 2-3 weeks after the			place or what systemic change will be made to ensure that the	_
	1st step, and the	n annually. If a resident			deficient practice does not rec	
	has had a previo	us reaction to the TB			Every new admission will rece	
	Mantoux test the	en we do a questionnaire			the first and second step mant	l l
		ck symptoms and chest			per facility policy.	

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155353		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 06/23/2	LETED	
	PROVIDER OR SUPPLIER		STREET A 1620 N	ADDRESS, CITY, STATE, ZIP CODE LINCOLN ST ISBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	x-ray." 3.1-18(e)			The Director of Nursing winservice licensed nurses of facility policy/procedure for mantoux skin test on July 2011. The admitting nurse administer the first step mand will ensure the second mantoux is added to the M be administered 1-3 weeks the first step. The admitting nurse for reference with the first step. The admitting nurse for reference with the first step. The admitting nurse for reference with the first step. The admitting nurse for reference with the first step. This process will continue indefinitely, on an ongoing of the MDS Coordinator/merecords designee shall perfect with the first step. The MDS Coordinator/merecords designee has been administed and to ensure the first step. MAR to be administered of three (3) weeks after the fifure of three (3) weeks after the fifure will be forwarded to the Dof Nurse's. The results of clinical record admission and the reviewed at the IDT medays per week. If the MDS Coordinator/merecords designee identifies	ill n the or 15, e will antoux step (AR to after sident ve failure basis dical form a udit on 4-48 tep othe ne (1) to rst step. cds e clinical e results irector the udit will eting 5	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/23/2011
	ROVIDER OR SUPPLIER		1620 N	ADDRESS, CITY, STATE, ZIP CODE LINCOLN ST NSBURG, IN47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				resident that has not received first step mantoux or the seconstep mantoux has not been and to the MAR she will immedia notify the charge nurse on duand the Director of Nurse's. 4. How will corrective action I monitored to ensure the defice practice does not recur and wow QA will be put into place? The Director of Nurse's and the MDS Coordinator will bring results of their QA audits to the monthly QA&A Committee meeting. The committee will review the results and provide recommendations for process improvement as needed. Any recommendations for improvement at the next QA&A meeting. While the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's review at least 5 does not result to the process of the Director of Nurse's reviews at least 5 does not result to the process of the Director of Nurse's review at least 5 does not result to the process of the Director of Nurse's not result to the process of the Director of Nurse's not result to the process of the Director of Nurse's not result to the process of the Director of Nurse's not result to the process of the Director of Nurse's not result	nd dded telv ty De ient chat he the he e ement rector the ions extor days vs

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155353		(X2) M A. BUII B. WIN	LDING G	NSTRUCTION 00	(X3) DATE S COMPL 06/23/2	ETED	
	PROVIDER OR SUPPLIER Y CREEK AT GREE			1620 N I	DDRESS, CITY, STATE, ZIP CODE LINCOLN ST SBURG, IN47240		
(X4) ID PREFIX TAG F0514 SS=D	(EACH DEFICIENT REGULATORY OR The facility must meach resident in action of the second secon	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) naintain clinical records on ecordance with accepted		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
	complete; accurate accessible; and sy The clinical record information to ider the resident's asse and services provipreadmission screstate; and progress Based on intervie facility failed to	ards and practices that are ely documented; readily estematically organized. must contain sufficient stiffy the resident; a record of essments; the plan of care ded; the results of any ening conducted by the es notes. ew and record review, the ensure clinical records documented in regard to	F0	0514	F 514 Clinical Records It is policy of this facility to maintain clinical records on	<u> </u>	07/23/2011
	advance directive urinary catheters outputs for urinar deficient practice residents in a san	es, physician orders for and recording of urinary ry catheters. This e affected 2 of 10 apple of 10 reviewed for mentation of clinical ants # 5 and #28)			each resident in accordance with acceptable professions standards and practices that are complete, accurately documented, readily access and systematically organize F514-1.a 1. What corrective action(s) will be accomplish for those residents found to have been affected by the deficient practice? Residen #15's attending physician w	al at sible ed. ned D	
	reviewed on 6-22 diagnoses include to diabetes mellit benign prostatic prostate), conges vein thrombosis a (blood clots in the chronic urinary respectively).	clinical record was 2-11 at 10:25 a.m. His ed, but were not limited tus type 2, hypertension, hypertrophy (enlarged tive heart failure, deep and pulmonary embolism e legs and lungs), etention, mild dementia, hronic pain. The clinical			notified for order clarification of the code status. The order clarification was faxed to the pharmacy so that the month physician's orders can be updated to included the order clarification. 2. How other residents having the potent to be affected by the same practice will be identified an what corrective action(s) with be taken? The Medical Recordinator and Social	er ne nly ler tial nd	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155353		A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/23/2011	
		100000	B. WIN			00/23/2011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE	
HICKOD.	Y CREEK AT GREE	NSBURG		1	LINCOLN ST SBURG, IN47240	
				<u> </u>	350KG, IN47240	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	1	IAG	Services Director shall aud	
	record indicated he had utilized a urinary catheter for several years due to urinary				every resident's medical re	
		,			to ensure the resuscitation	
		esident was admitted to			status form, advanced	_
	the facility on 12	-1-10.			directive, monthly physicia	<u>ın</u>
					orders (rewrites), sticker o	<u>n the</u>
		sident #5's advanced			residents door frame and	
	directive form, en	ntitled, "Resuscitation			sticker on the residents	. If
	Status Form," inc	dicated his POA (Power			medical record are accurated any discrepancies are	. e. 11
	of Attorney) had	indicated she desired for			identified the Director of	
	the resident to be	resuscitated in the event			Nursing shall be notified	
	that he stopped b	reathing or his heart			immediately and she will n	otify_
	stopped beating.	This form was undated.			the MD and residents legal	_
		otation indicated the			representative for code sta	
		a no-code status on his			clarification and document	
		e chart. It indicated the			the medical record and ens	
	_ :	en with the POA and she			the resuscitation form mor physician orders, sticker o	
		e a full code. It indicated			resident's door frame and	in the
					sticker on the resident's	
		uld be at the facility on			medical record are accurat	e. <u>3.</u>
	12-15-10.				What measures will be put	<u>into</u>
					place or what systemic	
		ent #5's recapitulation			changes will be made to	
		011 indicated the resident			ensure that the deficient practice does not recur? O	,
		Code," with an effective			admission of new resident	
	date for this liste	d as 12-16-10.			the Director of Nursing and	_
					Social Services manager s	
		erdisciplinary care plan			obtain in writing the reside	
	indicated the resi	dent's desire to be			and/or legal representative	
	resuscitated in th	e event he stopped			designation of the resident	
	breathing or his h	neart stopped beating.			code status. A list of reside	I
	This care plan ha	d an initial date of			having a "full code" status shall be maintained at the	-
	*	view dates of 3-10-11 and			nurse's station and will be	
	6-10-11 indicated				checked weekly by the Dire	
					of Nurses to ensure it is	_
	Review of physic	cian progress notes			current. The Director of	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155353	B. WIN			06/23/20	011
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	8			LINCOLN ST		
HICKOR	Y CREEK AT GREE	NSBURG			ISBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		-	DATE
	1	ysician had noted on			Nurses, Social Services		
	1-21-11 and 6-10	0-11 that the POA desired			Manager and licensed nurs shall be inserviced on ensu		
	for the resident t	o be a "Full Code."			the resuscitation status for		
					month physician order, stic		
	In interview with	n the Director of Nursing			on the resident's door fram		
	1	11 at 11:10 a.m., she			and sticker on the resident		
	` ′	s unaware of the			medical record are accurate		
					The MDS/medical records	_	
	1 -	ders listing Resident #5			designee will continue to		
		She indicated his care			complete new admission		
	plan and the advanced directive indicated				audits 24-48 hours after		
	he was to be a full code.				admission to the facility. Or	nce_	
					the MDS/medical records		
	b. Review of Re	esident #5's recapitulation			designee has completed the		
	orders for June 2	2011 indicated, "Change			new admission audits they		
		eter/urinary catheter)			be forwarded to the Directo	r or	
	1 '	entry had an effective			Nurses for follow-up as needed. On a quarterly bas	.	
	1 *				the care plan team will	<u>15,</u>	
	date listed as 12-	-10-10.			continue to review the		
					residents' code status as pa	art	
		n the DON on 6-22-11 at			of the care plan conference		
	2:05 p.m., she in	dicated the facility's			Any changes to the code st		
	policy regarding	urinary catheters, "says			of a resident will be followe	<u>d</u>	
	orders should in	clude a catheter size."			up by the DON at that time	to_	
					ensure the new code		
	On 6-22-11 at 11	1:30 a.m., the DON			designations have received		
	1	of a policy entitled,			appropriate colored sticker	_	
	1 ^ ^ *				designation. All newly hired		
	1	Indwelling," with an			nursing staff will continue	to	
		e 2004. The policy			receive orientation to the		
	1	k physician order. It			system for identifying residents code status, as w	ا	
	must include cat	heter size, balloon size,			as the facility policy regard		
	frequency of cha	inge, special catheter care			their response to finding a	<u>y</u>	
	and irrigation if	required."			unresponsive resident. 4. H	low	
					will corrective action be		
	C Review of Pa	esident #5's urinary output			monitored to ensure the		
		• •			deficient practice does not		
	records indicated	d the urinary output				•	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155353	B. WIN	G		06/23/2011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	LINCOLN ST	
HICKOR	Y CREEK AT GREE	NSBURG		GREEN	ISBURG, IN47240	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		as not routinely recorded			recur and what QA will be p	
	on the facility's in	ntake and output records.			into place? The Director of	<u> </u>
	Review of the M	arch 2011 output record			Nurse, Social Services Manager or MDS/medial	
	indicated 20 of 9	3 shift totals were absent.			records designee will revie	w at
	Review of the Ar	oril 2011 output record			least 3 resident's medical	
	1 ^	es of April 1 through 28			records at least 5 days per	
		d with 14 of 84 shift			week to ensure the	
		it, with the additional			resuscitation form, monthly	<u>v</u>
					physician orders, care plan	
		and 30 not present.			sticker on the residents do	<u>or</u>
		ay 2011 output record			frame and sticker on the	
	indicated 28 of 9	3 shift totals were absent.			resident's medical record h	
					the correct and appropriate	
	In interview with	the DON on 6-22-11 at			code designation. Results the medical record review	
	2:05 p.m., she inc	dicated, "The nurses are			be documented on the QA	
	to make sure the	I&O's (intakes and			audit form F 514-a. The QA	='
	outputs) are char	ted each shift." She			audit form will be brought t	_
	indicated the I&C	O's do not have to be			the monthly QA Committee	<u>.</u>
	charted on the tre	eatment record as there is			meeting for review and	
		nent this information.			recommendations. The	
		nent tins information.			committee will review the	
	On 6 22 11 ot 11	:30 a.m., the DON			results and provide	
					recommendations for proci improvement as needed. A	
	1 ^ ^ *	of a policy entitled,			recommendations for	<u>'''</u>
		out Measurement," with			improvement will be follow	ed
		une 2004. This policy			up by the Director of Nurse	<u>''s</u>
		dents with an indwelling			who will report on the resu	<u>lts</u>
		"measurement and			of those recommendations	
	documentation of	f intake and output every			the next QA&A meeting. The	
	eight hours, inclu	iding a 24 hour total."			documentation of their revi	
					will be done through the ne	
	2. Resident #28's	s clinical record was			30 days. Once that time fra is completed, the QA&A	ille
)-11 at 9:20 a.m. His			Committee will determine t	he
		ed, but were not limited			continued frequency of the	
	"	lial infarct (recent heart			review documentation. Dat	
	1	, cerebrovascular			Compliance: July 23, 2011.	
	attack), dementia	i, cerebrovascurar				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155353	B. WIN			06/23/2011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				LINCOLN ST	
HICKOD	Y CREEK AT GREE	NEDLIDO			ISBURG, IN47240	
піскок	T CREEK AT GREE	INSBURG		GREEN	NSBURG, IN47240	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE
	accident (stroke), diabetes type 2,				514-1.b 1. What corrective	
	coronary artery d	lisease, schizophrenia,			action(s) will be accomplish	
	depression, anxie	ety and restless leg			for those residents found to	<u> </u>
	•	as admitted into the			have been affected by the	
	facility on 7-21-0				deficient practice? On June	<u>: 22,</u>
	1acinty on 7-21-0	<i>J</i> 9.			2010 resident #5's foley	
					catheter orders were clarific	
		ent #28's clinical record			to include the catheter and balloon size. 2. How other	•
	indicated an abse	ence of information of his			residents having the poten	tial
	advance directive	e status (code status) on			to be affected by the same	<u></u>
	the June 2011 red	capitulation orders.			practice will be identified as	nd
		,			what corrective action(s) w	
	Pavious of the Sc	ocial Services progress			be taken? No other residen	
					was affected by this practic	_
		n entry, dated 5-20-11,			Two (2) residents with foley	
	"his code status i	s DNR (do not			catheterrs reside in the faci	-
	resuscitate.)"				at this time. Resident # 5's	
					orders for foley catheter ha	<u>ve</u>
	In interview with	the DON on 6-21-11 at			been clarified to include the	<u>. </u>
	 10·20 am she ii	ndicated the code status			size of the catheter and the	.
	· ·	recapitulation orders and			balloon. The other resident	_
		_			with a foley catheter residing	ng in
		d at the beginning of			the facility has had orders	
		e indicated she did not			foley catheter reviewed, and	
	find that informa	tion on Resident #28's			the size of the catheter and	- 1 1
	recapitulation or	ders.			balloon were present. 3. Wh	
	_				measures will be put into p	
	3.1-50(a)(1)				or what systemic changes v	
	3.1-50(a)(1) 3.1-50(a)(2)				be made to ensure that the	
	3.1-30(a)(2)				deficient practice does not recur? The licensed nurses	
					shall be inserviced on the	
					facility policy and procedur	_
					for	`
					"Catheterization-Indwelling	<u>". </u>
					including physician orders	
					catheter that include cathet	
					size, balloon size, frequenc	· I
					change, special catheter ca	·

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/23/2011		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
				and irrigation if required of July 15, 2011. In addition to above, at least 5 days perweek, the DON or designed review the 24 hour report a focus charting for any new orders for catheters-indwest The DON or designee will review the new orders and ensure the new order inclust the catheter size, balloon a frequency of change, special catheter care and irrigation required and indications for use. If the Director of Nursidentifies orders for cathete use that do not include the catheter size, balloon size frequency of change, special catheter care and irrigation required and indications for use the Director of Nurses notify the attending physic immediately for order clarifications and document the medical record. Once for the medical record. Once for the medical record. Once for the medical record of the staff involved. In addition, progressive disciplinary and will be taken for continued noncompliance. The Director of Nurses shall document findings on QA Audit form F-514-1.b, 5 days per weel This process will continued indefinitely and on an ong basis. 4. How will corrective action be monitored to ensure the deficient practice does	e will and L des size, sial of f e's er cial of f or will stan of tor tor of ction c		

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155353	A. BUILDING	00	COMPLETED 06/23/2011
		100000	B. WING	A PRINCIPLE OF THE CARE	00/23/2011
NAME OF P	ROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE LINCOLN ST	
HICKOR	Y CREEK AT GREE	NSBURG		ISBURG, IN47240	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
				recur and what QA will be into place? While the proc of the DON reviewing the 2 hour reports and focus charting at least 5 days per week is ongoing, the documentation of the reviewill be done through the name of the completed, the QA &A committee will determine the continued frequency of the review documentation. The DON will bring the results the QA audits to the interdisciplinary team mee 5 days per week, the week Standard of Care meeting, monthly QA&A meeting and the quarterly QA&A meeting and director for review and	ess ext ext eme he cof ting ly the d to eg dical
				recommendations. Date of Compliance: July 23, 2011	
				F514-1.c. 1. What corrective action(s) will be accomplise	
				for those residents found	
				have been affected by the	
				deficient practice? Per fac policy for Intake and Outp	-
				Measurement all residents	
				indwelling catheters shall	
				measurement and	
				documentation of intake a	nd
				output every eight (8) hou	' I
				including a 24-hour total. 2	
				How other residents havin	
				the potential to be affected	d by
				the same practice will be	tivo
				identified and what correc	<u>live</u>

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTII A. BUILDIN B. WING		00	(X3) DATE S' COMPLE 06/23/2 0	ETED
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL . LSC IDENTIFYING INFORMATION)	ID PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					action(s) will be taken? Ever residents medical record sl be audited to identify reside that per facility shall have intake and output measured and documented. Resident: identified as having indwell catheters, receiving enteral nurtitional therapy, receiving intravenous feeding, includ TPN, with specific physicial orders for measurements of intake and output, an order fluid restriction or encouragement shall have intake and output measurement per facility policy. 3. What measures where put into place or what systemic changes will be more to ensure that the deficient practice does not recur? The Director of Nursing will inservice both licensed and non-licensed nursing staff the facility policy and procedure for "Intake and Output Measurement". The Dietary Manager or designed will audit the Fluid & Meal Percentage Intake Log at less days per week to ensure intake has been recorded for the previous day. The charnurse will audit intake & our measurement logs every state to ensure the output has be recorded before the end of his/her shift. The Director of Nurses shall review the intakent in the previous shall review the intakent interest of the previous shall review the intakent interest intakent intakent intakent intakent interest intakent into the previous day. The charnurse will audit intake & our measurement logs every state on the previous day. The charnurse will audit intakent intakent into the previous day. The charnurse will audit intakent intakent into the previous day. The charnurse will audit intakent intakent into the previous day. The charnurse will audit intakent intakent into the previous day. The charnurse will audit intakent into the previous day into the previous day. The charnurse will audit intakent into the previous day into the previous day.	hall ents d s ling ng ling n's f or rill nade lon ee ast or ge tput hift een of	

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/23/2011		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GREENSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION DATE		
				& output measurement to least 5 days per week to tboth the intake and outphave been recorded for t previous day. The Direct Nurses shall document findings on QA Audit form F-514-1.c, 5 days per we This process will continuindefinitely and on an on basis. 4. How will correct action be monitored to enthe deficient practice document and what QA will be into place? Date of Compliance: July 23, 201 514-2 1. What corrective action(s) will be accompliance been affected by the deficient practice? The attending physician and resident legal representative will be contacted for clarification of code state. Once the attending physician and resident legal representative and faxed to the pharmacy to ensure the status appears correctly monthly physician order addition to the above the representative and attending physician shall sign the "Resuscitation Status Form designating code status. How other residents have the potential to be affect the same practice will be	ensure but he sor of m ek. le going tive nsure es not e put 1. F ished 1 to e tive lician de code on the s. In legal ding ing ed by		

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 06/23/2011
		155353	B. WING		00/23/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
HICKODY	V ODEEN AT ODEE	NCDUDO		LINCOLN ST	
HICKOR	Y CREEK AT GREE		GREEN	ISBURG, IN47240	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COM ELTION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
				identified and what correct	
				action(s) will be taken? The Medical Records Coordinates	
				and Social Services Direct	
				shall audit every resident'	
				medical record to ensure	
				resuscitation status form,	_
				advanced directive, month	<u>nly</u>
				physician orders (rewrites	
				sticker on the residents de	<u>oor</u>
				frame and sticker on the residents medical record	ara
				accurate. If any discrepan	
				are identified the Director	
				Nursing shall be notified	
				immediately and she will r	notify_
				the MD and residents lega	<u>l</u>
				representative for code st	atus_
				clarification, document in	
				medical record and ensure	
				resuscitation form, month	
				physician orders, sticker or resident's door frame and	
				sticker on the resident's	-
				medical record are accura	ite. 3.
				What measures will be pu	t into
				place or what systemic	
				changes will be made to	
				ensure that the deficient	<u>. </u>
				practice does not recur?	
				admission of new residen the Director of Nursing an	
				Social Services manager	
				obtain in writing the residence	
				and/or legal representative	
				designation of the residen	ıt's
				code status. A list of resid	
				having a "full code" status	
				shall be maintained at the	
				nurse's station and will be	<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SGR511

Facility ID:

000244

If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER: 155353	A. BUILDING	00	COMPLETED 06/23/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/20/2011
NAME OF I	PROVIDER OR SUPPLIER			LINCOLN ST	
HICKOR'	Y CREEK AT GREE	NSBURG	GREEN	ISBURG, IN47240	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COM ELTION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	checked weekly by the Dir of Nurses to ensure it is current. The Director of Nurses, Social Services Manager and licensed nur shall be inserviced on ensure it is month physician order, ston the resident's door frait and sticker on the resident medical record are accurated to the MDS/medical records designee will continue to complete new admission audits 24-48 hours after admission to the facility. Of the MDS/medical records designee has completed to the MDS/medical records designee has completed to the MDS/medical records designee has completed to the Direct Nurses for follow-up as needed. On a quarterly bathe care plan team will continue to review the residents' code status as of the care plan conference. Any changes to the code of a resident will be follow up by the DON at that time ensure the new code designations have received appropriate colored sticked designation. All newly him nursing staff will continue receive orientation to the system for identifying residents code status, as as the facility policy regar their response to finding a unresponsive resident. 4.	ses suring orm, icker me tt's tte. Dince he y will tor of sis, part ee. status red e to ed the er ed e to well ding ding ding

AND PLAN OF CORRECTION		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE COI LDING	00		(X3) DATE COMPL	
		155353	B. WIN				06/23/2	011
NAME OF F	PROVIDER OR SUPPLIER		'	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
	Y CREEK AT GREE			1	LINCOLN ST SBURG, IN47240	1		
				<u> </u>				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLA (EACH CORRECTIVE A	N OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED DEFICII	TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFTING INFORMATION)	<u> </u>	IAG				DATE
					will corrective monitored to e			
					deficient pract	_		
					recur and wha			
					into place? Th			
					Nurse, Social S		='	
					Manager or MI	OS/medial		
					records design	<u>nee will revie</u>	<u>w at</u>	
					least 3 residen			
					records at leas			
					week to ensure resuscitation f			
					physician orde			
					sticker on the			
					frame and stic		<u> </u>	
					resident's med		ave	
					the correct and			
					code designat	ion. Results o	of_	
					the medical re	cord review	will_	
					be documente			
					audit form F 5		_	
					audit form will			
					the monthly Q		-	
					meeting for rev recommendati			
					committee will			
					results and pro			
					recommendati		ess_	
					improvement a	as needed. Aı	<u>1y</u>	
					<u>recommendati</u>			
					improvement v			
					up by the Direc			
					who will report			
					of those recon the next QA&A			
					documentation			
					will be done th			
					30 days. Once	-		
					is completed, t		<u> </u>	
					Committee wil	l determine th	<u>1e</u>	
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	SGR511	Facility I	D: 000244	If continuation sl	neet Pa	ge 32 of 33

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155353	A. BUILDING B. WING	00	COMPLETED 06/23/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	1
	Y CREEK AT GREE			LINCOLN ST ISBURG, IN47240	
(X4) ID		TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFTING INFORMATION)	IAG	continued frequency of the	
				review documentation. D Compliance: July 23, 201	
				Compliance: July 23, 201	''